AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I,, hereby aut	horize (Name of person or facility which h	as information) to		
release the following health informa	ation:			
To:				
(Name of person/title or facility to receive health information)				
(Street address, city, state, ZIP code)	(Telephone number) (F	ax number)		
For the purpose of:				
This authorization is in effect until_	(date or event) wh	en it expires.		

I understand that by signing this authorization:

- I authorize the use or disclosure of my individually identifiable health information as described above for the purpose listed. I understand that this authorization is voluntary.
- I understand the Notice of Privacy Practices provides instructions should I choose to revoke my authorization.
- I understand if the organization I have authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.
- I understand I have the right to receive a copy of this authorization.
- I understand that I am signing this authorization voluntarily and that treatment, payment, or eligibility for my benefits will not be affected if I do not sign this authorization.

I DECLARE UNDER PENALTY OF PERJURY THAT THE INFORMATION ON THIS FORM IS TRUE AND CORRECT.

SIGNATURE	DATE

IDENTIFYING INFORMATION			
☐ COPY OF IDENTIFICATION ATTACHED			
TYPE IDENTIFICATION CARD, BIRTH CERTIFI IDENTIFICATION CARD, MANAGED CAR EMPLOYEE ID CARD)	·		
NUMBER			
IF NO IDENTIFICATION IS ATTACHED, YOUR SIGNATURE MUST BE			
NOTARIZED.			
NOTARIZED BY			
ON	(DATE)		
NOTARY PUBLIC NUMBER			
UNOFFICIAL UNLESS STAMPED BY NOTARY PUBLIC			